



National Indian Health Board NATIONAL TRIBAL COVID-19 RESPONSE

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What is the role of health insurance for American Indian and Alaska Natives (AI/ANs) who are patients of Indian health programs during the COVID-19 Crisis?

Outline

WHAT IS THE ROLE OF HEALTH INSURANCE FOR AMERICAN INDIAN AND ALASKA NATIVES (AI/ANS) WHO ARE PATIENTS OF INDIAN HEALTH PROGRAMS DURING THE COVID-19 CRISIS?	1
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Background

This paper will examine the impact of health insurance status (with or without insurance) during the COVID-19 pandemic. The data cited in the paper comes from the U.S. Census Bureau's American Community Survey and is supplemented by state-level reports and administrative data from the Centers for Medicare, Medicaid, and Children's Health Services and the Indian Health Service.

The health insurance status of AI/ANs can be categorized into seven categories:

1. The Indian Health Service, Tribes Purchase and Referred Care budget
2. The uninsured
3. The underinsured
4. Medicaid
5. Medicare
6. Private insurance in the Marketplace Federal and state Exchanges (Obamacare)
7. Private Employer-sponsored Insurance



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Private employer plans

About 32% of AI/ANs with access to IHS programs have coverage through [employer-sponsored health plans](#). The impact of COVID-19 will vary by plan and its cost sharing provisions.

COVID-19: Many health plans are required to provide payment for COVID testing and treatment without copays or cost sharing, in some states this is an insurance requirement by states' insurance regulations. In addition, many health insurance plans have voluntarily removed cost sharing. It is important to note that ERISA, Employer self-insured plans, are not regulated by states and many Tribes do have self-insured plans. Employees who are laid-off have 18 month of eligibility if they are willing to pay the full cost of the health plan (COBRA), but most AI/ANs will choose their Indian health program instead of continuing private coverage.

Health Insurance Provided through Health Care Exchanges

About [100,000 AI/ANs are enrolled](#) in these plans. Enrollment is greater in states without Medicaid expansion, with large numbers of enrolled tribal members, with tribal sponsorship of premiums, and a high percentage of AI/ANs between 100% and 300% of the federal poverty level. For example, Oklahoma has over 10% of national enrollment. Nationally over 200,000 AI/ANs are eligible but not enrolled. They may not enroll in private health plans because the premiums and co-pays are too expensive. They depend on the Purchase and Referred Care (PRC) program to pay their health care bills, creating a strain on PRC budgets.

COVID-19: The federal government requires that all exchanges' health plans provide payment for COVID testing, but the insured are required to pay for treatment with copays and cost sharing.

If someone is laid-off from a job with an employer-sponsored health plan they have 60 days to enroll in an exchange health plan under the "special enrollment" provision. The Trump Administration has decided not to join all thirteen state exchange plans in creating an open enrollment period for all the uninsured who live in states that have not opened their own state exchange. That means only the recently unemployed uninsured are eligible for the existing special enrollment period.

Medicare

The good news is that over 90% of AI/ANs 65 and older have at least Medicare Part A, and some research suggests over 90% with Part A also have Part B or one of the Part C options. A smaller, but unknown percentage have prescription coverage in Part C or Part D.



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COVID-19: Those with original Medicare Part A and Part B will be subject to cost sharing for COVID-19 testing and treatment. (at the time of writing). Medicare Advantage plans will not charge copays or cost-sharing for COVID-19 testing and treatment. This is an evolving crisis however and the reader should check the current status of exemptions from cost sharing.

Medicaid

About [35% of all patients of Indian health programs](#) are enrolled in Medicaid. However, with recent layoffs, many AI/ANs may lose their employer-sponsored coverage. Since some of these people will be eligible for Medicaid, we can expect an increase in the percentage of patients enrolled in the program. Many have never had Medicaid so it will be important that outreach and education efforts are tailored to the recently unemployed.

COVID-19: Several provisions of the COVID-19 legislation impact Medicaid including the offer of an increase in the FMAP by 6.2% points (Medicaid ‘bump’) in exchange for the maintenance of effort requirements to essentially not reduce eligibility or add administrative burdens for enrollment. The future of Medicaid benefits and eligibility is in doubt when the ‘bump’ expires, currently at the end of the quarter when the Presidential Emergency Declaration ends.

The Underinsured

Many AI/ANs are employed in service industries, in particular in the hospitality industry, which has some of the highest rates of high deductible health insurance plans with high cost sharing provisions. There is no estimate of the number of ‘underinsured AI/ANs’. This is an important category because the health care behavior of the underinsured is similar to that of the uninsured. Care is sought too late and often at the wrong location (often emergency rooms). Primary care and the regular maintenance of chronic conditions, like diabetes and pre-diabetes are particular concerns for AI/ANs.

COVID-19: When an underinsured person considers going to a primary care provider or an emergency room they often pause and wait longer than is medically advisable. The result can be disastrous, particularly during an epidemic like COVID-19.

Uninsured

[Uninsured AI/ANs](#) are most at risk during the COVID-19 crisis and the [patients of Indian health programs are more likely to be uninsured](#) than those who are not patients of these programs. Care is sought too late and often at the wrong location (often emergency rooms). Primary care and the regular maintenance of chronic conditions is neglected and the results are worsened conditions and often a higher cost of health care to address the result of this neglect.



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COVID-19: When an uninsured person delays primary care they often end up in an emergency room. The delay may result in greater morbidity or death particularly during an epidemic like COVID-19. Unless clear guidance is given about whether or not treatment costs will be paid by the federal government, many will continue to act as if they are uninsured. Currently, doubt remains about federal funding and other specifics of proposals to pay for COVID-19 related medical costs despite several reports that the Administration is considering this provision using funds from the \$100 billion ‘hospital fund.’

Note: In this essay coronavirus is the virus and COVID-19 is the disease.

Indian Health Service-funded Tribal and Direct Service health programs

Tribal communities see their health programs as the fulfillment of the federal trust responsibility to provide care that is equal to that of any other American, which means many AI/ANs consider Indian health programs their main source of health care services. These programs accept patients with private and public insurance and a large number of patients are either uninsured or underinsured. In addition to funding for the direct care provided by these programs, one budget known as Purchased and Referred Care (PRC) is available for care provided by specialists and hospitals and other providers and services.

COVID-19: As third party revenue goes down due to social distancing and reduced provider hours at health programs, costs and expenditures will rise as patients seek care at non-I/T facilities and there is already a severe strain on the PRC budget as bills are processed for this care. In addition, large medical expenses occurring this late in Fiscal Year 2020 are not likely to be paid by the Comprehensive Health Emergency Fund if this fund is already exhausted with the claims of a normal pre-COVID-19 expenses.

Conclusion

One can only conclude that health insurance, private or public, will not be sufficient to cover the increase in demands for preventive and medically necessary services due the increased demands of the COVID-19 pandemic. A system already struggling in a normal year cannot be expected to marshal an adequate response to the crisis without massive inputs of resources: financial and administrative. Tribal governments are best able to decide where these resources should be deployed. New funding needs to be flexible and sufficient to the demands of this new challenge to an already financially compromised system of care.